ENDODONTIC SPECIALISTS OF OAKHURST

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PATIENT INFORMATION

Last Name _____ First _____Middle _____
Billing Address _____
City_____ State _____ Zip Code_____
Home Phone _____ Business Phone _____ Cell Phone _____
Sex_____ Date of Birth _____ Social Security Number _____
Email Address _____
Employer Name _____ Occupation _____
Address _____
City _____ State _____ Zip Code _____
Driver's License Number _____ State _____ Marital Status _____
Spouse's Name _____
Referred By _____
Present Dentist _____

DENTAL INSURANCE INFORMATION

Insured's Name _____
Insured's Social Security Number _____ Insured's Date of Birth _____
Insurance Carrier _____ Insurance Phone # _____
Employer _____ Group Number _____
Employer Phone # _____
Secondary Insurance Carrier (if applicable) _____

FINANCIAL POLICY AND INSURANCE ASSIGNMENT

I, the undersigned certify that I (or my dependent) have insurance coverage with the above stated company and assign directly to Dr. Franklin all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event that the insurance company does not make a payment towards my account within 45 days, I will remit payment for the full balance as expected. In the event that my account goes 60 days past due, I understand that monthly late fees may be applied to my account at a rate of 10% of the remaining principle balance. Accounts 120 days past due may be transferred to collections for receivable assistance, and additional service fees may be applied. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: **Date:**

Although this office files insurance claims as a service to our patients, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient.